TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Health Fort Worth

Respondent Name
Ace American Insurance Co

MFDR Tracking Number
M4-16-3320-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
June 27, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per the new fee schedule this account qualifies for an Outlier payment…"

Amount in Dispute: $1,711.96

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill was priced per CMS OPPS allowable APC rate of $1,063.07 @ 200%, or $2,126.14."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 15, 2015	Outpatient Hospital Services	$1,711.96	$17.62

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for services provided in an outpatient hospital setting.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - MOPS – Services reduced to the Outpatient Perspective Payment System (OPPS)
   - MSIN – This is a packaged item. Services or procedures included in the APC rate, but not paid separately
   - Z710 – The charge for this procedure exceeds the fee schedule allowance
   - P300 – Charge fee schedule/maximum allowable or contracted/legislated fee arrangement

- U634 – Procedure code not separately payable under Medicare and or fee schedule guidelines
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

The services in dispute are for outpatient hospital services and are therefore subject to the requirements of 28 Texas Administrative Code 134.403 (d) which states in pertinent part, "For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided..." The applicable Medicare payment policy may be found at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html.

In order to calculate the correct Division fee guideline, stakeholders should be familiar with the main components in the calculation of the Medicare payment for OPPS services which are found at:

1. **How Payment Rates Are Set**, found at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HospitalOutpaysysfctsht.pdf,
   To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate (60 percent) is further adjusted by the hospital wage index for the area where payment is being made. The remaining 40 percent is not adjusted.
2. **Payment status indicator** - The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPS or under another payment system or fee schedule. The relevant status indicator may be found at the following: www.cms.gov, Hospital Outpatient Prospective Payment – Final Rule, OPPS Addenda, Addendum D1.
3. **APC payment groups** - Each HCPCS code for which separate payment is made under the OPPS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting. The relevant payment amount for each APC may be found at: www.cms.gov, Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Annual-Policy-Files, Addendum B. These files are updated quarterly.
4. **Composite** - Composite APCs provide a single payment for a comprehensive diagnostic and/or treatment service that is defined, for purposes of the APC, as a service typically reported with multiple HCPCS codes. When HCPCS codes that meet the criteria for payment of the composite APC are billed on the same date of service, CMS makes a single payment for all of the codes as a whole, rather than paying individually for each code.
5. **Outliers** - The OPPS determines eligibility for outliers using either a "multiple" threshold, which is the product of a multiplier and the APC payment rate, or a combination of a multiple and fixed-dollar threshold. A service or group of services becomes eligible for outlier payments when the cost of the service or group of services estimated using the hospital's most recent overall cost-to-charge ratio (CCR) separately exceeds each relevant threshold. The outlier payment is a percentage of the difference between the cost estimate and the multiple threshold. The CMS OPPS Web site at www.cms.hhs.gov/HospitalOutpatientPPS/ under "Annual Policy Files" includes a table depicting the specific hospital and CMHC outlier thresholds and the payment percentages in place for each year of the OPPS.

Issues

1. What is the applicable rule that pertains to reimbursement?
2. Is the carriers' denial supported?
3. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §134.403 (f) states in pertinent part,

The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

(1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

(A) 200 percent;

The services in dispute are reimbursed based on the following.

Submitted code	Status Indicator	Composite Criteria met?	APC / Composite	Payment Rate	Unadjusted labor amount = APC payment x 60%	Geographically adjusted labor amount = unadjusted labor amount x annual wage index or 0.9512	Non labor portion = APC payment rate x 40%	Medicare facility specific reimbursement (geographically adjusted labor) amount + non labor portion)	Maximum Allowable Reimbursement
71010	Q3	NO	0260	$59.37	$59.37 x 60% = $35.62	$35.62 x 0.9512 = $33.88	$59.37x 40% = $23.75	$33.88 + $23.75 = $57.63	$57.63 x 200% = $115.26
72125	Q3	YES	8006	$528.36	$528.36 x 60% = $317.02	$317.02 x 0.9512 = $301.55	$528.36 x 40% = $211.34	$310.55 + $211.34 = $521.89	$521.89 x 200% = $1,043.78
74177	Q3	YES	8006	Included in above					
70450	Q3	YES	8006	Included in above					
71260	Q3	YES	8006	Included in above					
99284	Q3	NO – Observation of eight or more hours not performed	0615	$333.80	$333.80 x 60% = $200.28	$200.28 x 0.9512 = $190.51	$333.80 x 40% = $133.52	$190.51 + $133.52 = $324.03	$324.03 x 200% = $648.06
96361	S	n/a	0436	$32.58	$32.58 x 60% = $19.55	$19.55 x 0.9512 = $18.60	$32.58 x 40% = $13.03	$18.60 + $13.03 = $31.63	$31.63 x 200% = $63.26
96374	S	n/a	0438	$108.24	$108.24 x 60% = $64.94	$64.94 x 0.9512 = $61.77	$108.24 x 40% = $43.30	$61.77 + $43.30 = $105.07	$105.07 x 2 = $210.14
96375	S	n/a	0436	$32.58	$32.58 x 60% = $19.55	$19.55 x 0.9512 = $18.60	$32.58 x 40% = $13.03	$18.60 + $13.03 = $31.63	$31.63 x 200% = $63.26
								Total	$2,143.76

Payment for **outliers** is available when the following requirements outlined at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9014.pdf are met.

Code	OPPS Payment	Estimated cost of service = Total OPPS charges x 2015 Cost to charge rationale for facility or 0.198	Outlier eligibility threshold = Line-item APC payment x 1.75	2015 Fixed-dollar threshold ($2,775) plus APC payment amount	Both thresholds met or exceeded?
71010	$59.37	$452.25 x 0.198 = $89.55	$59.37 x 1.75 = $103.90	$59.37 + $2,7775 = $2,834.37	NO
72070	$95.02	$438.75 x 0.198 = $86.87	$95.02 x 1.75 = $166.29	$95.02 + $2,7775 = $2,870.02	NO
72125	$528.36	$13,029.75 x 0.198 = $2,579.89	$528.36 x 1.75 = $924.63	$528.36 + $2,7775 = $3,303.36	NO
99284	$333.80	$987.00 x 0.198 = $195.43	$333.80 x 1.75 = $584.15	$333.80 + $2,7775 = $3,108.80	NO
96361	$32.58	$71.25 x 0.198 = $14.11	$32.58 x 1.75 = $57.02	$32.58 + $2,7775 = $2,807.58	NO
96374	$108.24	$223.75 x 0.198 = $44.30	$108.24 x 1.75 = $189.42	$108.24 + $2,7775 = $2,883.24	NO
96375	$32.58	$223.75 x 0.198 = $44.30	$32.58 x 1.75 = $57.02	$32.58 + $2,7775 = $2,807.58	NO

Based on the above table the estimated cost for each line item does not exceed required thresholds. Therefore, no additional payment for outliers is due.

2. The insurance carrier denied disputed services with claim adjustment reason code MSIN – "This is a packaged item. Services or procedures included in the APC rate, but not paid separately" and U634 – "Procedure code not separately payable under Medicare and or fee schedule guidelines." 28 Texas Administrative Code §134.403 (d) which states in pertinent part, "For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided…"

The applicable payment indicator for the following services in dispute are listed below:

- Procedure code J7030 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code 36415 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code 80048 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code 85025 has status indicator N denoting packaged items and services with no separate APC payment.

- Procedure code 72170 has status indicator Q1 denoting STVX-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X performed on the same date.
- Procedure code 73090 has status indicator Q1 denoting STVX-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X performed on the same date.
- Procedure code 76376 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J2270 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J2405 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code Q9967 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code G0390 describes trauma activation associated with hospital critical care services. Review of the submitted medical bill finds no billing code that represents critical care services were provided. Therefore, this code is not separately payable.

3. The maximum allowable reimbursement is $2,143.76. The Carrier previously paid $2,126.14. The remaining balance of $17.62 is due to the requestor.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $17.62.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $17.62 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order

Authorized Signature

	Peggy Miller	July , 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.